



**MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2007**

CIGNA HEALTHCARE - CENTENNIAL STATE, INC

**8525 East Orchard Road
Greenwood Village, CO, 80111**

**NAIC Company Code 901
NAIC Group Code 95412**



CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

**Cigna HealthCare - Centennial State, Inc.
8525 East Orchard Road
Greenwood Village, Colorado 80111**

**LIMITED SCOPE MARKET CONDUCT
EXAMINATION REPORT
as of
December 31, 2007**

Examination Performed by:

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

State Market Conduct Examiner

November 3, 2009

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Morrison:

This market conduct desk examination of Cigna HealthCare - Centennial State, Inc. was conducted pursuant to §§ 10-1-201, 10-1-203, 10-1-204, and 10-16-416, C.R.S., which authorize the Insurance Commissioner to examine health maintenance organizations. The Company's records were examined at the Division of Insurance offices located at 1560 Broadway Suite 850 Denver, Colorado, 80202. The market conduct examination covered the period from January 1, 2007, through December 31, 2007.

The following market conduct examiner respectfully submits the results of the examination:

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

**MARKET CONDUCT
EXAMINATION REPORT
OF
CIGNA HEALTHCARE - CENTENNIAL STATE, INC.**

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COMPANY PROFILE

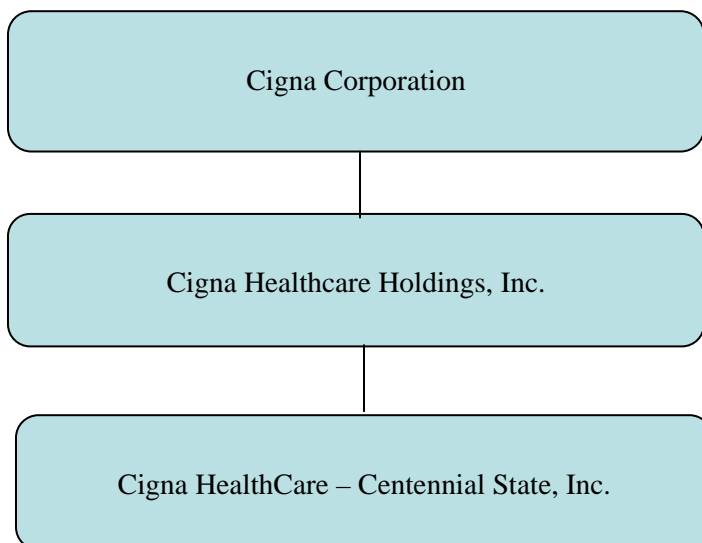
Cigna HealthCare - Centennial State, Inc. (Company) f/k/a Great-West Healthcare of Colorado, Inc. is a wholly owned subsidiary of Cigna Healthcare Holdings, Inc., which is a wholly owned subsidiary of Cigna Corporation. The Company was previously a subsidiary of Great-West Life and Annuity Insurance Company, and was acquired by Connecticut General Life Insurance Company (CGLIC), on April 1, 2008. A Corporate structure chart is included on the following page.

The Company operates as a health maintenance organization and received its Certificate of Authority from the State of Colorado on July 11, 1996. The original counties included as the area of service in the Company's application are: Adams, Arapahoe, Boulder, Clear Creek, Denver, Douglas, El Paso, Elbert, Gilpin, Grand, Jefferson, Larimer, Pueblo, Teller, and Weld counties in Colorado. The Company continues to serve those counties as of the date of this report.

Effective January 2009, the Company has ceased issuing new policies, resulting from its decision to exit the group health market in Colorado. As of that date, the Company was only writing large group HMO business. This action is the result of the Company's acquisition by the Cigna Corporation. Colorado insurance law requires a notice of non-renewal at least 180 days prior to the non-renewal of the policy, and the non-renewal must occur on the policy renewal or anniversary date. Therefore, policyholders with renewals scheduled through July 2009 will be allowed to retain their policies if they so elect, until the next renewal date. Membership is expected to be zero by July 2010, at which time a fifteen (15) month claims run-out period will begin.

Corporate Structure as of April 1, 2008

The following organizational chart depicts the Company's relationship within the company structure as of April 1, 2008.



Service Area

The Company is licensed to provide services in Adams, Arapahoe, Boulder, Clear Creek, Denver, Douglas, El Paso, Elbert, Gilpin, Grand, Jefferson, Larimer, Pueblo, Teller, and Weld counties in Colorado.

Enrollment As of 12-31-07: 4,404

Total Written Premium as of 12-31-07 (Large Group Only): \$23,063,000

Market Share - _Colorado Group Accident &Health Insurance 0.48%

Health Care Delivery:

Cigna HealthCare - Centennial State, Inc. contracts with independent physician associations, physician group practices, and independent physicians, as well as hospitals, mental health facilities and other ancillary providers to provide primary and specialty care. The Company pays for health care services through negotiated fee-for-service arrangements.

PURPOSE AND SCOPE OF EXAMINATION

A State market conduct examiner with the Colorado Division of Insurance (Division), in accordance with Colorado Insurance Laws, §§ 10-1-201, 10-1-203, 10-1-204 and specifically 10-16-416, C.R.S., which empower the Commissioner to require any company, entity, or new applicant to be examined, reviewed certain business practices of Cigna HealthCare - Centennial State, Inc. The findings in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of the examination was to determine the Company's compliance with Colorado insurance laws related to Health Maintenance Organizations (HMO's). Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

The examiner conducted the examination in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners. The examiner relied primarily on records and materials maintained and/or provided by the Company. The market conduct examination covered the period from January 1, 2007 through December 31, 2007.

The examination included review of the following:

- Company Operations and Management;
- Claims; and
- Utilization Review

The final exam report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on the review of the above areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiner's comments.

For the period under examination, the examiner included statutory citations and regulatory references related to HMO's. Examination findings may result in administrative action by the Division. The examiner may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any HMO or product.

An error tolerance level of plus or minus ten dollars (\$10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar (\$0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar (\$0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of seven percent (7%) for claims, or ten percent (10%) for other samples, was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g., timeliness of claims payment), and if one or more of the samples yielded an exception rate higher than the minimum tolerance level, the results

of any other samples with exception percentages less than the minimum tolerance threshold were also included.

EXAMINER'S METHODOLOGY

The examiner reviewed the Company's business practices to determine compliance with Colorado insurance laws and regulations as they pertain to HMO's as shown in Exhibit 1.

Exhibit 1

Statute or Regulation	Subject
Section 10-1-128, C.R.S.	Fraudulent insurance acts - immunity for furnishing information relating to suspected insurance fraud - legislative declaration.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-104, C.R.S.	Mandatory coverage provisions – definitions.
Section 10-16-104.3, C.R.S.	Dependent health coverage for persons under twenty-five years of age.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-113.7, C.R.S.	Reporting the denial of benefits to the division.
Section 10-16-401, C.R.S.	Establishment of health maintenance organizations.
Section 10-16-403, C.R.S.	Powers of health maintenance organizations.
Section 10-16-413, C.R.S.	Prohibited practices
Section 10-16-421, C.R.S.	Statutory construction and relationship to other laws.
Section 10-16-423, C.R.S.	Confidentiality of health information.
Section 10-16-427, C.R.S.	Contractual relations.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration – repeal.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties and Timelines Concerning Division Inquiries and Document Requests
Insurance Regulation 4-2-5	Hospital Definition
Insurance Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits
Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-Existing Conditions
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 4-2-24	Concerning Clean Claim Requirements for Health Carriers
Insurance Regulation 4-6-9	Conversion Coverage
Insurance Regulation 4-7-1	Health Maintenance Organizations
Insurance Regulation 4-7-2	Concerning the Laws Regulation Health Maintenance Organization Benefit Contracts and Services in Colorado

Company Operations/Management

The examiner reviewed Company management and administrative controls, record retention, and timely cooperation with the examination process.

Claims

The examiner selected random samples of 109 paid and 108 denied HMO claims from populations of 77,008 and 5,193, respectively that were received during the period of January 1, 2007 through December 31, 2007. These claims were reviewed for the Company's overall claims handling practices and to determine accuracy of processing.

The examiner also reviewed the entire population of twenty-one (21) electronic claims paid beyond thirty (30) days, and twenty-four (24) non-electronic claims paid beyond forty-five (45) days to determine the Company's compliance with Colorado's prompt payment of claims law. In addition, the examiner reviewed a total population of six (6) claims that were not paid or settled within ninety (90) days after receipt. These claims were reviewed to determine if they had been delayed due to fraud, and if not, if interest and penalties had been paid.

Utilization Review

The examiner reviewed the Company's utilization management program including policies and procedures. The examiner also reviewed the total population of thirty (30) first level review appeal files and three (3) second level appeal review files. In addition, the examiner reviewed a randomly selected sample of eighty-three (83) utilization review (UR) approvals from a population of 521, and the total population of fifty-four (54) UR denial decisions. These sample files were reviewed for the Company's overall UR handling practices, as well as timeliness of completing the review and communication of the decisions to the appropriate persons.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of two (2) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiner's findings and recommendations.

Company Operations/Management: In the area of company operations and management, no compliance issues are addressed in this report.

Claims: The examiner identified one (1) area of concern in the review of the claims handling practices of the Company.

Issue J1: Failure, in some instances, to allow thirty (30) days to provide additional information before denying claims.

Utilization Review: The examiner identified one (1) area of concern in the review of the Company's Utilization Review procedures.

Issue K1: Failure, in some instances, to have written denials of adverse utilization review determinations signed by a licensed physician.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

CIGNA HEALTHCARE - CENTENNIAL STATE, INC.

<p><u>CLAIMS</u></p>

Issue J1: Failure, in some instances, to allow thirty (30) days to provide additional information before denying claims.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states in part:

- (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean Claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

...

- (4)(b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4). [Emphases added.]*

DENIED CLAIMS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
5,193	108	14	13%

Using ACL™ software, the examiner identified a summarized population of 5,193 claims denied during the examination period. A random sample of 108 such claims was selected for review.

It appears the Company is not in compliance with Colorado insurance law in that fourteen (14) of the reviewed claims were denied at the same time additional information was requested, without waiting the required thirty (30) calendar days for the additional information to be submitted. Further, the Company explained verbally that claims needing additional information for the Company to determine its liability are denied in the claim system. The explanation of benefits statement (EOB) issued in connection with the denial of the claim includes information regarding what information is needed to resolve the claim, as

well as instructions for resubmitting the claim: When the claim is resubmitted with the needed information, the Company treats it as a new claim with a new claim number and received date.

Colorado's prompt claim payment law allows a Company to deny claims needing additional information only after notifying the appropriate individual of the information needed and allowing the individual thirty (30) calendar days for the information to be provided.

Recommendation No. 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has modified its procedures to ensure that whenever additional information is needed to resolve an unclear claim, the claim is kept open for at least thirty (30) days to allow the requested information to be provided.

UTILIZATION REVIEW

Issue K1: Failure, in some instances, to have written denials of adverse utilization review determinations signed by a licensed physician.

Section 10-16-113, C.R.S, Procedure for denial of benefits – rules, states in part:

- (4) All written denials of requests for covered benefits on the ground that such benefits are not medically necessary, appropriate, effective, or efficient shall be signed by a licensed physician familiar with standards of care in Colorado.

Adverse Utilization Review Determination Letters

Population	Sample Size	Number of Exceptions	Percentage to Sample
54	54	10	19%

The examiner reviewed the entire population of fifty-four (54) utilization review files involving adverse determinations made during calendar year 2007. It appears that the Company is not in compliance with Colorado insurance law in that ten (10) files contained notification letters that did not include the signature of a licensed physician.

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-113, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that all adverse utilization review decisions are signed by a licensed physician familiar with standards of care in Colorado.

SUMMARY OF ISSUES AND RECOMMENDATIONS

ISSUES	Rec. No.	Page No.
CLAIMS		
Issue J1: Failure, in some instances, to allow thirty (30) days to provide additional information before denying claims.	1.	16
UTILIZATION REVIEW		
Issue K1: Failure, in some instances, to have written denials of adverse utilization review determinations signed by a licensed physician.	2.	18

State Market Conduct Examiner

Jeffory Olson, CIE, FLMI, AIRC, ALHC

Conducted this examination and prepared this report

For

**The Colorado Division of Insurance
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Denver, Colorado 80202**